UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Xifaxan (rifaximin)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES TO 855-828-4992

CRITERIA:

- Traveler's Diarrhea:
  - Age ≥ 12 years
  - For treatment, not for prophylaxis
  - Trial and failure of, or contraindication to, a fluoroquinolone or azithromycin – please describe
  - Must reasonably be believed to be caused by *Escherichia coli* – please describe
  - Maximum 200mg three times daily for 3 days

- Overt Hepatic Encephalopathy
  - Age ≥ 18 years
  - For prophylaxis of recurrence – please describe previous occurrences and therapies
  - Trial and failure of, or contraindication to, properly titrated doses of lactulose – please describe
  - Maximum 550mg twice daily

AUTHORIZATION:

Traveler's Diarrhea: 3 days
Overt Hepatic Encephalopathy: 1 year

RE-AUTHORIZATION:

Letter of medical necessity describing treatment efficacy and rational for continuation

08/06/2013